



Key Themes and Highlights From the National Healthcare Disparities Report

The United States health care delivery system is among the world's finest with outstanding providers, facilities, and technology. Many Americans enjoy easy access to care. However, not all Americans have full access to high quality health care.

Released in 2003, the first National Healthcare Disparities Report (NHDR) is a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations. This second NHDR is built upon the 2003 report and continues to include a comprehensive national overview of disparities in health care in America. In addition, in the 2004 report, a second critical goal of the report is developed: tracking the Nation's progress towards the elimination of health care disparities.

In the 2004 report, three key themes are highlighted for policymakers, clinicians, health system administrators, and community leaders who seek to use this information to improve health care services for all Americans:

- Disparities are pervasive.
- Improvement is possible.
- Gaps in information exist, especially for specific conditions and populations.

Disparities Are Pervasive

Consistent with extensive research and findings in the 2003 report, the 2004 report finds that disparities related to race, ethnicity, and socioeconomic statusⁱ pervade the American health care system. While varying in magnitude by condition and population, disparities are observed in almost all aspects of health care, including:

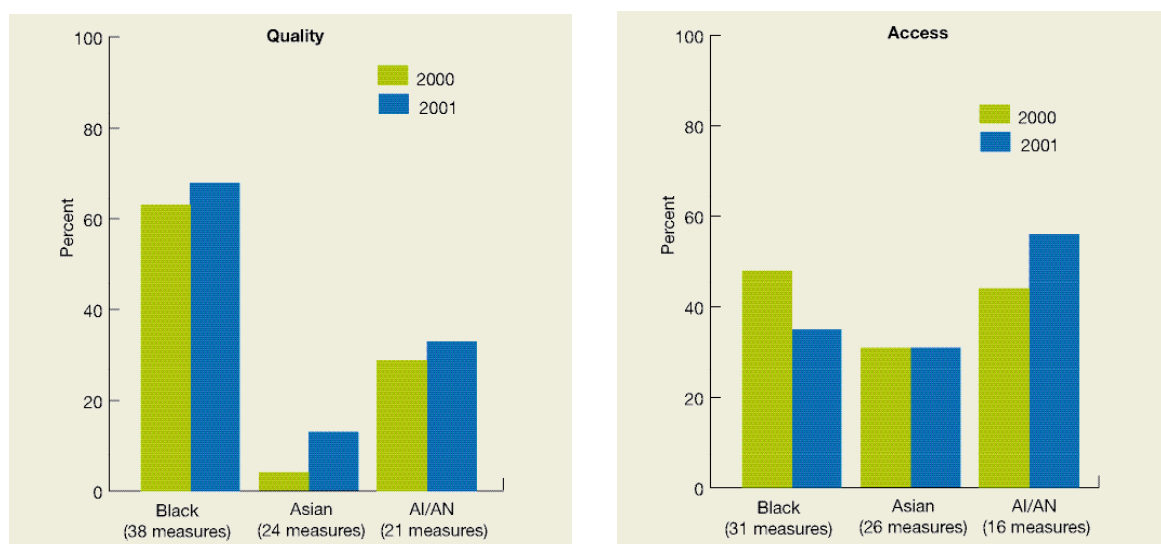
- Across all dimensions of quality of health care including effectiveness, patient safety, timeliness, and patient centeredness.
- Across all dimensions of access to care including getting into the health care system, getting care within the health care system, patient perceptions of care, and health care utilization.
- Across many levels and types of care including preventive care, acute care, and chronic care.
- Across many clinical conditions including cancer, diabetes, end stage renal disease, heart disease, and respiratory diseases.
- Across many care settings including primary care, dental care, mental health care, substance abuse treatment, emergency rooms, hospitals, and nursing homes.
- Within many subpopulations including women, children, elderly, persons with disabilities, residents of rural areas, and individuals with special health care needs.

ⁱConsistent with Healthy People 2010, the NHDR defines disparities as any differences among populations. In addition, all disparities discussed in the NHDR meet criteria based on statistical significance and size of difference described in Chapter 1. Income and education are the primary measures of socioeconomic status used in the report.



To begin to quantify disparities systematically, a subset of measures for which comparable data are available for 2000 and 2001 are highlighted in the 2004 report. This subset consists of 38 measures of effectiveness of health care and 31 measures of access to health care. Data sources are the Surveillance, Epidemiology, and End Results (SEER) program, U.S. Renal Data System (USRDS), Medical Expenditure Panel Survey (MEPS), the Centers for Disease Control and Prevention (CDC) AIDS Surveillance System, National Vital Statistics System-Nativity (NVSS-N), National Immunization Survey (NIS), National Health Interview Survey (NHIS), and National Hospital Discharge Survey (NHDS). For each measure, racial, ethnic, and socioeconomic groups are compared with an appropriate comparison group; each group could receive care that is poorer than, about the same as, or better than the comparison group.ⁱⁱ For each group, the percentage of measures for which the group received poorer care was then calculated.

Figure H.1. Percent of measures for which members of selected racial groups experience poorer quality of care (left) or have worse access to care (right) compared with whites in 2000 and 2001



Source: SEER, USRDS, MEPS, CDC AIDS Surveillance System, NVSS-N, NIS, NHIS, NHDS, 2000-2001.

Note: Poorer quality of care and worse access to care indicate that for a particular measure, the group does not receive as high quality care or have as much access to care as whites and that the relative difference is at least 10% and statistically significant with $p < 0.05$. Number of measures available for each group is indicated in parentheses.

Key: AI/AN=American Indian and Alaska Native

Of measures tracked in 2000 and 2001, in both years:

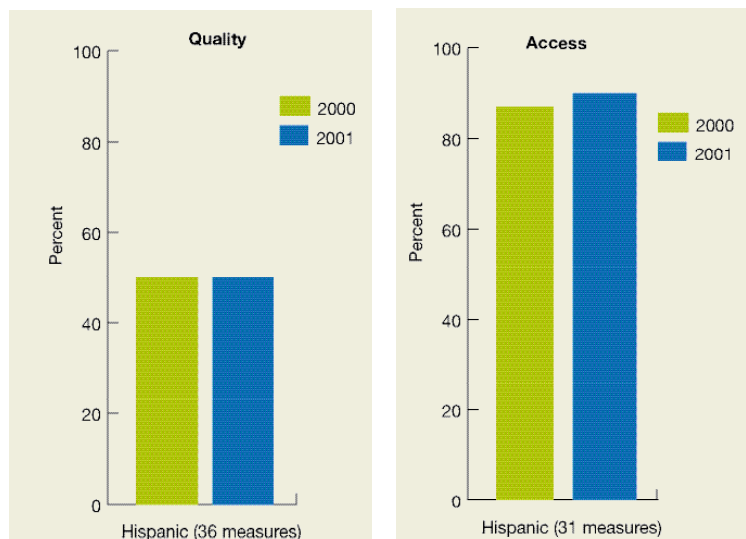
- Blacks received poorer quality of care than whites for about two-thirds of quality measures and had worse access to care than whites for about 40% of access measures (Figure H.1).
- Asiansⁱⁱⁱ received poorer quality of care than whites for about 10% of quality measures and had worse access to care than whites for about a third of access measures.
- American Indians and Alaska Natives (AI/ANs) received poorer quality of care than whites for about a third of quality measures and had worse access to care than whites for about half of access measures.

ⁱⁱ Data on all measures were not available for all groups; see Tables 1.2 and 1.3 for lists of measures available for each group. Only relative differences of at least 10% and statistically significant with $p < 0.05$ are discussed in this report.

ⁱⁱⁱ Including "Asians or Pacific Islanders (APIs)" when information is not collected separately for each group.



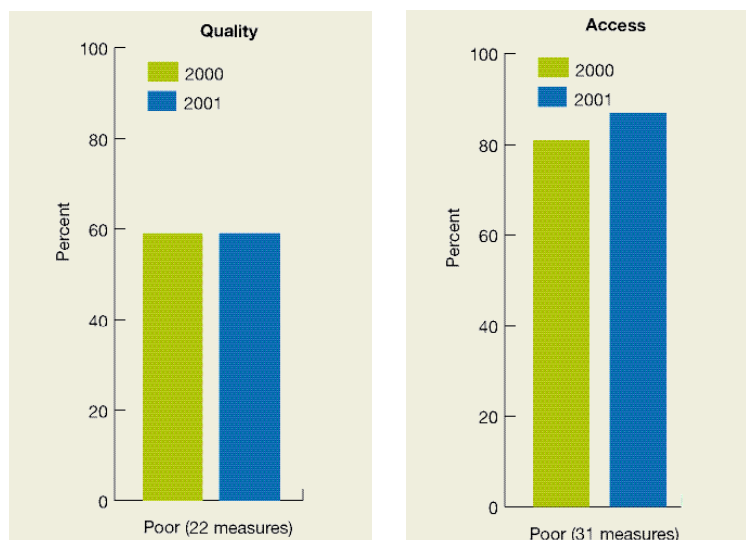
Figure H.2. Percent of measures for which Hispanics experience poorer quality of care (left) or have worse access to care (right) compared with non-Hispanic whites in 2000 and 2001



Source: SEER, USRDS, MEPS, CDC AIDS Surveillance System, NVSS-N, NIS, NHIS, NHDS, 2000-2001.

Note: Poorer quality of care and worse access to care indicate that for a particular measure, the group does not receive as high quality care or have as much access to care as non-Hispanic whites and that the relative difference is at least 10% and statistically significant with $p < 0.05$. Number of measures available for each group is indicated in parentheses.

Figure H.3. Percent of measures for which the poor experience poorer quality of care (left) or have worse access to care (right) compared with high income individuals in 2000 and 2001



Source: SEER, USRDS, MEPS, CDC AIDS Surveillance System, NVSS-N, NIS, NHIS, NHDS, 2000-2001.

Note: Poorer quality of care and worse access to care indicate that for a particular measure, the group does not receive as high quality care or have as much access to care as high income individuals and that the relative difference is at least 10% and statistically significant with $p < 0.05$. Number of measures available for each group is indicated in parentheses.

Of measures tracked in 2000 and 2001, in both years:

- Hispanics received lower quality of care than non-Hispanic whites for half of quality measures and had worse access to care than non-Hispanic whites for about 90% of access measures (Figure H.2).
- Poor people^{iv} received lower quality of care for about 60% of quality measures and had worse access to care for about 80% of access measures than those with high income (Figure H.3).

^{iv}“Poor” is defined as having family incomes less than 100% of the Federal poverty level and “high income” is defined as having family incomes 400% or more of the Federal poverty level.



Improvement Is Possible

The Department of Health and Human Services (HHS) leads many initiatives aimed at reducing health care disparities and improving health care quality. While cause and effect relationships would be difficult to demonstrate, these activities are often associated with improvements in care. In the 2003 report, several examples of the absence or reversal of disparity that coincided with HHS programs were identified, including:

- Absence of racial or ethnic disparity in management of anemia among end stage renal disease patients in 2001, coinciding with the Centers for Medicare & Medicaid Services End Stage Renal Disease Clinical Performance Measures Project.
- Higher rates of Pap testing among black compared with white women in 2000, coinciding with the CDC National Breast and Cervical Cancer Early Detection Program.
- Higher rates of blood pressure monitoring among blacks compared with whites in 1998, coinciding with the National Heart, Lung, and Blood Institute National High Blood Pressure Education Program.

In the 2004 report, new examples of decreasing disparities in health care are added, including:

- Elimination of racial, ethnic, and socioeconomic disparities in quality of and access to health care observed among people who receive care in community health centers.
- Elimination of differences in rates of late stage breast cancer between black and white women from 1992 to 2001 due to falling rates among black women coupled with rising rates among white women. This result may be related to the CDC National Breast and Cervical Cancer Early Detection Program and improving rates of mammography among black women.
- Lower rates of measles-mumps-rubella vaccination for black children age 19-35 months compared with white children and lower rates of *Haemophilus influenzae* vaccination for Hispanic children compared with non-Hispanic white children in 2000 but no significant differences in 2002. These results may in part be related to the CDC National Immunization Program.
- Lower rates of influenza vaccination for elderly Asian and Pacific Islander Medicare beneficiaries than white beneficiaries in 1998 but no significant difference in 2000.
- Less likelihood that blacks and Asians would report a source of ongoing care compared with whites in 1999 but no significant differences in 2001.

While these examples demonstrate that improvement is possible, reducing disparities is a gradual process. In the 2004 report, the accumulation of more than a single year of data for many measures allows the examination of changes over time. While changes over 2 years of data are difficult to interpret, these changes are presented in this report to illustrate the tracking function of the NHDR. It is hoped that future reports with more years of data will be able to document sustained reductions in health care disparities.

In general, from one year to the next, improvements in measures of quality of or access to health care are small, and disparities are particularly slow to change. For all racial, ethnic, and socioeconomic groups, specific disparities observed in 2000 were almost always observed in 2001 as well (Figures H.1-H.3). Even when improvement in quality or access is observed, disparities often persist because all groups typically change proportionately. To reduce disparities, groups with poorer quality of care or access to care need to experience more rapid improvement in care than other groups and this is rarely observed.



Longer term trends are better able to capture improvements in health care over time but generally support the thesis that disparities change gradually. For example, the three SEER measures used in the report are trended over a decade. For two of these, significant changes over the decade are demonstrated; rates of late stage colorectal and cervical cancer fell while rates of late stage breast cancer remained constant. However, most of the racial and ethnic differences in late stage cancer observed in 1992 are still present in 2001.

Gaps in Information Exist, Especially for Specific Conditions and Populations

In the 2003 report, providing a comprehensive national overview of disparities in health care was limited by a number of gaps in information, including:

- Few measures for some conditions such as quality of HIV care and mental health care.
- Few measures that were unique but important to specific populations.
- Limited data to address particular population groups such as children, the elderly, persons with disabilities, residents of rural areas, and individuals with special health care needs or at the end of life.
- Limited data to address Hispanic and Asian subpopulations and barriers related to language and literacy.
- Limited data to understand why disparities exist and how they can be eliminated.

In the 2004 report, efforts to address some of these information gaps have begun, including:

- More measures of unique and high importance to children and to the elderly.
- Information about hospital care received by American Indians and Alaska Natives from Indian Health Service facilities.
- Information about care delivered in community health centers from the Health Resources and Services Administration Community Health Center User Survey.
- Information about children with special health care needs from the National Survey of Children with Special Health Care Needs.
- Expanded analyses of residents along the urban-rural continuum using the new Federal classification system.
- Expanded stratified and multivariate analyses that begin to disaggregate disparities related to race and ethnicity from disparities related to socioeconomic status.

However, many gaps in information remain. For example, of the subset of measures tracked between 2000 and 2001, statistically reliable estimates were not possible for:

- The vast majority of measures among Native Hawaiians and Other Pacific Islanders.
- About half of measures among American Indians and Alaska Natives.
- About a third of quality of care measures among Asians.



Future NHDRs will benefit from ever improving data for examining and tracking disparities. For example, MEPS data for the 2005 report will include large oversamples of Asians and people with incomes less than 200% of the Federal poverty level and will add new survey questions about language and cultural competency. NHIS data will also begin to include oversamples of Asians. The increasing number of health plans that are beginning to collect data on race and ethnicity will improve understanding of disparities in health care. The revolution in health information technologies will allow data needed to assess disparities to be collected and processed more quickly, efficiently, securely, and economically.

As knowledge of disparities in health care and commitment to reducing disparities continue to grow, the ability to monitor and track improvements in disparities will become critical. In the 2004 report, work begun in 2003 to lay the information infrastructure needed to track the Nation's progress towards the elimination of disparities in health care is continued and expanded. Working together, using the NHDR as a guide, America's patients, providers, purchasers, and policymakers can make full access to high quality health care a reality for all.